Executive Council of Physical Therapy and Occupational Therapy Examiners
333 Guadalupe, Ste 2-510 512/305-6900 • 512/305-6951 fax
Austin, Texas 78701-3942 http://www.ptot.texas.gov

App. No:_____

Cert. No:_____

OT Facility Registration Application

Name of Facility: _____

Physical Address: _____

_____
City Zip

_____
Area Code/Phone No. Fax#

Mailing Address (if different from above)_____

_____

_____

Check one box below	**Check one box below**
☐ New Facility Registration ☐ Change of Owner (if yes, please answer below) Previous Registration # _____	Is this the only facility registered by this owner? ☐ YES ☐ NO

Owner Information
Type of Business (Check one) ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Government Entity

Owner's Federal Taxpayer ID Number (SSN allowed only if the owner is a sole proprietor and has no Federal employee ID number. Enter one number only.)

EIN ☐☐ – ☐☐☐☐☐☐☐ **or SSN** ☐☐☐ – ☐☐ – ☐☐☐☐

Name of the Owner: If the entity is a sole proprietorship operated under the name of the owner, enter that name both here and in the contact information field on page 2.

For use by agency staff only

Completed by: _____ Fee Received_____
Initial and date

Reviewed by:_____ Receipt No._____
Initial and date

App. No:_____

Owner Contact Information:

- If Sole Proprietor: Enter the information for the owner in the Name 1 box.
- If Governmental Entity: Enter contact information for the person authorized to act for the entity in the Name 1 box.
- If Partnership or Corporation: Enter contact information for the managing partner or officer in the Name 1 box and the other three (3) top officers in charge of occupational therapy facility operations in the other boxes provided.

Name 1			
Address			
City, State & Zip		Area Code & Phone #	
Date of Birth		SSN#	

Name 2			
Address			
City, State & Zip		Area Code & Phone #	
Date of Birth		SSN#	

Name 3			
Address			
City, State & Zip		Area Code & Phone #	
Date of Birth		SSN#	

Name 4			
Address			
City, State & Zip		Area Code & Phone #	
Date of Birth		SSN	

SIGNATURE OF OWNER (or DESIGNEE)

The information submitted in this application is true and correct to the best of my knowledge.

☐ Owner ☐ Designee, relationship to facility_____

_____

Printed Name Title

_____

Signature Phone Number

_____

Email

App. No:_____

You are required by rule to supply a list of OTs and OTAs working in the facility. Do NOT include the name of the Therapist in Charge, whose name goes in the TIC box below. Attach another page if you need to add more names.

Licensee's Name	License #

Signature of OT in Charge

PLEASE NOTE: According to OT Rule §376.4, a change in Therapist in Charge must be reported to the board within 30 days. Your name will be officially listed with this facility unless you notify us otherwise.

I hereby affirm that I have authority and responsibility for the registered facility's compliance with the OT Act and Rules. I swear that the information submitted on this form is true and correct to the best of my knowledge.

_____
Printed Name

_____
Signature

_____
License # Date